Department of Health and Human Services

Division of Services for the Blind

**Supported Employment Extended Services Vendor Application (New/Renewal)**

**Applicant Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Organization Name: |  | Date: |  |

Organization Type:  Profit  Non-Profit

|  |  |
| --- | --- |
| Director: |  |
| Contact Person: |  |
| Billing Address: |  |
| Physical Address: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone: | ( ) | Director’s Email: |  |

|  |  |
| --- | --- |
| Target Population(s): |  |

Describe your organization’s experiences with the target population(s).

|  |  |
| --- | --- |
|  |  |
|  |  |
| Contact Person’s Email: |  |
| Counties Served: |  |
|  |  |

1. Organizational Information:

**For the following documentation, please provide an index, label and attach:**

* 1. Please describe your agency’s mission, vision and explain your organization’s core values.

1. Your organization’s policies on the following areas
2. Conflict of Interest
3. Criminal Background Checks
4. Consumer Complaints
5. Consumer Satisfaction
6. Consumer Grievance
7. ADA Policy
8. Staff Training
9. Informed Choice
10. Accessibility Standard/Physical Accessibility
11. Health and Safety Standard
12. Affirmative Action Policy
13. Fiscal Management Policy
14. Program Evaluation Standard
15. Provide job descriptions for direct service staff including minimum qualifications
16. Supporting Documentation:
    1. A copy of your accreditation certificate, outcome report, and quality improvement plan. If not accredited attached your plan for accreditation.
    2. Any other current and valid licenses, accreditation letters or certifications, if applicable.
    3. Your corporate charter, if applicable.
    4. Certification of good standing for franchise taxes, if applicable.
    5. Documentation of nonprofit status, if applicable.
    6. A roster of your board of directors, if applicable, including names and addresses.
    7. A copy of your organization chart if applicable.

**Conflict of Interest Certification**

Real or apparent conflicts of interest may occur when a DVRS employee, officer or immediate family member has a financial or other interest in the business relationship involving a provider and that interest might reasonably be expected to influence the outcome of an official action. If it is found that such conflict of interest occurs and is not disclosed and remedied, the provider or potential provider may be barred from performing authorized services with NC DSB; and existing authorization and vendor approval may be cancelled. If a real or apparent conflict of interest exists, attach a separate sheet describing the situation.

|  |
| --- |
| I certify, by signature below, that no real or apparent conflict of interest exists between the applicant organization and NC DSB. |

|  |
| --- |
| Signature: |

**Acknowledgment and Signature**

|  |
| --- |
| I hereby acknowledge that I have been provided with the NCDSB Standards for Providers of Community Rehabilitation Programs, have read and agree to abide by them and I am making application on behalf of the provider named above to become an approved provider of Supported Employment Extended Services with NC DSB. |

|  |  |  |  |
| --- | --- | --- | --- |
| Printed Name: |  |  |  |
| Signature: |  | Date: |  |

Date received by DSB:

Responsible District Supervisor:

For NC DSB Use Only